STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING _____ B. WING _____	03/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEGATE VILLAGE LLC	7510 ROSEGATE DR INDIANAPOLIS, IN46237

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/07/11 Facility Number: 011149 Provider Number: 155757 AIM Number: 200829340 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Rosegate Village LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident rooms and all areas not separated from the corridor. The facility has a capacity of 150 and a census of 146.	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after April 6, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/18/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0038 SS=E	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, requires approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to	K0038	**1) Whati corrective action(s) will be accomplished fior tihose residentis fiound tio have been afiectied by tihe deficienti practice?** No residentts were ftound tto have any negattve outtcome by tthe ftndings. **2) How will you identifiy otiher residentis having tihe potiential tio be afiectied by tihe same deficienti practice and whati corrective action will be tiaken?** All residentts have tthe pottenttal tto be aftectted by tthe ftndingThe ftrontt lobby exitt door was repaired so tthatt itt now releases when tthe door handle is pushed ftor more tthan15 seconds. All exitt doors equipped witth delayed egress locks were checked ftor proper operatton and ftound tto be in proper operattng order. **3) Whati measures will be puti intio place or whati systiemic changes you will make tio ensure tihati tihe deficienti practice does noti recur?** 7 oft 7means oft egress witth delayed egress locks are now readily accessible tto all residentts,sttaft and visittors As partt oft tthe ongoing ftacilitty preventtattve mainttenance program, tthe Mainttenance Directtor inspectts delayed egress locks ftor proper operatton on a weekly basis.	04/06/2011

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	be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less that 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect any residents, staff and visitors using the Main Lobby exit. Findings include: Based on observation with the Maintenance Supervisor during the tour of the facility from 11:25 a.m. to 1:45 p.m. on 03/07/11, the Main Lobby exit door set is equipped with a sign stating "PUSH UNTIL ALARM SOUNDS DOORS CAN BE OPENED IN FIFTEEN SECONDS." In addition, the Main Lobby exit door set is equipped with delayed egress locks but		The Executtve Directtor reviews tthe completted Preventtattve Mainttenance Log montthly ongoing **4) How tihe corrective action(s) will be monitiored tio ensure tihe deficienti practice will noti recuri.e., whati qualitiy assurance program will be puti intio place?** All exitts doors equipped witth delayed egress locks will be monittored ftor proper operatton by tthe Executtve Directto/designee weekly X 4 weeks, montthly X2 montths and quartterly tthereafter Resultts oft tthe auditt will be presentted tto tthe CQI Committee montthly tto ensure compliance and ftollow-up. Identtfted noncompliance may resultt in sttaft r-educatton and/or disciplinary actton.	

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	the exit door would not release when the door handle was pushed for more than fifteen seconds. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the Main Lobby exit door set should have opened when the door handle was pushed for more than fifteen seconds. 3.1-19(b)			

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K0045 SS=E	Based on observation and interview, the facility failed to ensure the lighting for 2 of 7 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect any of the residents, as well as staff, and visitors needing to exit the facility from the 100 Hall exit and the 400 Hall exit. Findings include: Based on observation with the Maintenance Supervisor during the tour of the facility from 11:25 a.m. to 1:45 p.m. on 03/07/11, the exit means of egress outside the 100 Hall exit and the 400 Hall exit are each equipped with one light fixture with only one bulb. Based on interview at the time of observation, the Maintenance Supervisor acknowledged only one light fixture with one bulb was provided at each of these exits. 3.1-19(b)	K0045	**1) Whati corrective action(s) will be accomplished fior tihose residentis fiound tio have been afiectied by tihe deficienti practice?** No residentts were ftound tto have any negattve outtcome by tthe ftndings. **2) How will you identifiy otiher residentis having tihe potiential tio be afiectied by tihe same deficienti practice and whati corrective action will be tiaken?** All residentts have tthe pottenttal tto be aftectted by tthe ftndingThe lightt ftxttures outtside oft100 and 400 hall exitts have been replaced witth multt-bulb ftxttures so tthatt tthe ftailure oft one bulb will nott leave tthe area in darkness. **3) Whati measures will be puti intio place or whati systiemic changes you will make tio ensure tihati tihe deficienti practice does noti recur?** 7 oft 7exitt means oft egress are now arranged so tthatt tthe ftailure oft any single lightt ftxttur(bulb) will nott leave tthe area in darkness As partt oft tthe ongoing ftacilitty preventtattve mainttenance program, tthe Mainttenance Directtor inspectts extterior lighttng on a daily basis The Executtve Directtor reviews tthe completted Preventtattve Mainttenance Log montthly ongoing	04/06/2011

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			4) How tihe corrective action(s) will be monitiored tio ensure tihe deficienti practice will noti recuri.e., whati qualitiy assurance program will be puti intio place? The Executtve Directto/designee will inspectt exitt means oft egress lighttng ftor proper operatton weekly X4, montthly X2 montths and quartterly tthereafter tto meett tthe requirementts oft NFPA101 Lifte Saftetty Sttandards Resultts oft tthe auditt will be presentted tto tthe CQI Committee montthly tto ensure compliance and ftollow-up. Identtfted noncompliance may resultt in sttaft r-educatton and/or disciplinary actton.	

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K0050 SS=F	Based on record review and interview, the facility failed to conduct fire drills in 4 of 4 calendar quarters. This deficient practice affects all residents in the facility including staff. Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor from 9:20 a.m. to 11:20 a.m. on 03/07/11, fire drill records were not available for review for the shifts listed below for the following calendar quarters: A) Third shift for the first calendar quarter of 2010. B) First, second and third shift for the second calendar quarter in 2010. C) First and third shift for the third calendar quarter of 2010. D) First shift for the fourth calendar quarter of 2010. Based on interview at the time of record review, the Maintenance Supervisor stated the former Maintenance Supervisor for the facility was terminated after September 2010 and acknowledged fire drill records were not available for review for the aforementioned shifts and quarters. 3.1-19(b) 3.1-51(c)	K0050	**1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have any negative outcome by the findings. **2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the finding. Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift. **3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director will be in-serviced on the importance of proper scheduling and documentation of facility fire drill requirements. The Maintenance Director will monitor the current fire drill schedule to comply with NFPA 101 Life Safety Standards. **4) How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Executive Director will review the current fire drill schedule and Preventative Maintenance Log as they relate to fire drill procedures weekly X 4	04/06/2011

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			months, monthly X 2 months and quarterly thereafter to meet the requirements of NFPA 101 Life Safety Standards. Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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K0144 SS=F	1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 28 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Weekly Inspection Checklist" documentation with the Maintenance Supervisor from 9:20 a.m. to 11:20 a.m. on 03/07/11, the only documented dates of a generator battery weekly inspections	K0144	**1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have any negative outcome by the findings. **2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the finding. **3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** As part of the ongoing facility preventative maintenance program, the Maintenance Director conducts and documents weekly generator batter inspections and monthly generator load tests. The Executive Director reviews the completed Preventative Maintenance Log monthly ongoing. **4) How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Executive Director will review the Preventative Maintenance Log to ensure compliance with required generator inspections weekly X 4 months, monthly X 2 months and	04/06/2011

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	available for review were from 09/22/10 through 02/28/11. Weekly generator battery inspections for the period of 03/07/10 through 09/15/10 were not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the former Maintenance Supervisor for the facility was terminated after September 2010 and acknowledged weekly generator records prior to September 2010 were not available for review. 3.1-19(b) 2. Based on record review and interview for 6 of 12 months, the facility failed to exercise the generator to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required		quarterly thereafter. Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Weekly Exercise/Monthly Load Test Log" documentation with the Maintenance Supervisor from 9:20 a.m. to 11:20 a.m. on 03/07/11, monthly generator load test documentation was available for review for the period 09/21/10 through 02/14/11. Monthly load test documentation was not available for review for the period of March 2010 through August 2010. Based on interview at the time of record review, the Maintenance Supervisor stated the former Maintenance Supervisor for the facility was terminated after September 2010 and acknowledged monthly generator load test documentation prior to September 2010 was not available for review. 3.1-19(b)			